Haynes (W. H.)

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Report of a Case, with Anæsthesia of Supra-orbital Branch of the Fifth Cranial Nerve.

BY

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REPORT OF A CASE, WITH ANÆSTHESIA OF SUPRAORBITAL BRANCH OF THE FIFTH CRANIAL NERVE.

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Katie T., aged eleven years and a half, a bright, intelligent, quick-witted schoolgirl, born and reared in Brooklyn; with a good negative family history, especially as to syphilis, malaria, rheumatism, and the like; and a medical history of attacks of whooping-cough, measles, and chicken-pox, with attacks of headaches at times. One week after school opened this fall (September, 1896) felt headache in the top of her head and over eyes, without nausea, and mother noticed that she did not open her right eye, which was full of water; lids stuck together on awakening in the morning, eye felt sore, and it was thought she had taken cold. Four days later, when Dr. Scott Wood saw her at the Brooklyn Eye and Ear Hospital, he noticed the above-described condition and also ascertained the loss of sensation of the right supraorbital region without any visual defects, and referred her to the neurological department, where the following conditions were noticed: She is apparently a well-nour-

ished, intelligent girl, suffering pain in the top of her head and right eyeball; says sight of that eye is foggy. Right upper eyelid covers upper half of that eyeball. There is no discharge present; lids do not now agglutinate, but there is loss of tactile and pain sense throughout the right half of the forehead and temporal region covering the distribution of the supraorbital branch of the trifacial nerve of that side. Otherwise she is perfectly well.

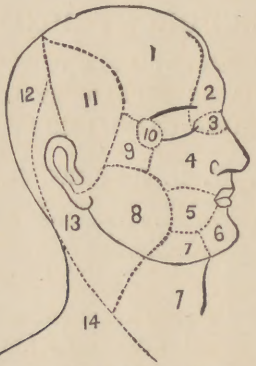

FIG. 1.—The cutaneous nerve distribution of the head. After Flower, but slightly modified. 1, region supplied by the supraorbital branch of the fifth nerve; 2, region supplied by the supratrochlear branch of the fifth nerve; 3, region supplied by the infratrochlear branch of the fifth nerve; 4, region supplied by the infraorbital branch of the fifth nerve; 5, region supplied by the buccal branch of the fifth nerve; 6, region supplied by the mental branch of the fifth nerve; 7, region supplied by the superficial cervical from the cervical plexus; 8, region supplied by the great auricular from the cervical plexus; 9, region supplied by the temporo-malar branch of the fifth nerve; 10, region supplied by the lacrymal branch of the fifth nerve; 11, region supplied by the auriculo-temporal branch of the fifth nerve; 12, region supplied by the great occipital (a spinal nerve); 13, region supplied by the small occipital from the cervical plexus; 14, region supplied by the supraclavicurauf or lthe cervical plexus.

The diagnosis of migraine with ptosis and anæsthesia of supraorbital branch of the fifth nerve was made and treatment given, first of bromide of sodium, then of arsenic, without apparent benefit, and finally,

at Dr. John C. Shaw's suggestion, one two-hundredth of a grain of aconitine (Duquesnel's), three times a day, which last caused disappearance of the pain and apparent gradual recovery of power over eyelid; so that six weeks after attacks began she could elevate the lid as well as the other; sensation had wholly returned; still had slight pain in eyeball, but no discharge or sticking, and sight is perfectly normal.

The attention of the profession was first called to this complaint through the celebrated paper of Saundby's in the *Lancet* for September 2, 1882, though his were not the first cases noticed and reported. In this country Dr. John C. Shaw, of Brooklyn, was the first to report a case of this kind, and he collected all in reach at the time of the publication of his paper, entitled Migraine with Intermittent Ptosis, read before the Medical Society of the State of New York in 1886, and printed in its *Transactions* for that year. The last and most complete article on the subject is that of Dr. P. C. Knapp's, under the title of Recurrent Motor Ocular Paralysis, and published in the *Boston Medical and Surgical Journal*, vol. cxxxi, 1894, page 308, and includes a complete bibliography excepting the case reported by Dr. Shaw, an abstract of which is as follows:

A boy, aged seven years, with a healthy negative family history, suffered from a mild attack of measles when six months old, followed two months later by a swelling of his left eye and drooping of its upper lid, so that the eyeball could only be seen when the lid was lifted; this was recovered from some time after. When two years old he had another attack without pain, and which soon passed off. At five years, another, in which there were attacks of severe recurring pain in the eyeball of a sharp, darting character, lasting about five min-

utes; he suffered the pain for two weeks, the ptosis two months, and his mother thinks they were due to cold. At six years of age he had another similar attack, but of shorter duration. During his next year he had several attacks of pain, in the last of which the paralysis seems to have continued in a less marked degree than during his previous attacks. He is a stout, healthy looking boy, myopic, with marked paresis of all the muscles supplied by the left third cranial nerve; dilated pupil which reacts very little to light. At this time he suffers no pain, and examination with the ophthalmoscope shows a normal fundus. Two months later he presented himself, suffering severe pain in the temple, but more so in eyeball, for the past two days, attended with nausea and a little vomiting, which we now learn is the character of the beginning of his previous attacks, and the ptosis is more marked than when he was last seen. After two days the pain subsided; the ptosis grew less within a month, but never entirely passed off, and when at rest the eyeball would move out a little, but if he attempted to use the eye the internal rectus would act for a few minutes and then became relaxed.

This is eminently a disease of childhood and youth, as nearly all the cases reported occurred during the first and second decades of life, or the early attacks took place during that time. It occurs equally in males and females, and in the same proportion on either side. There is in some cases a family history of a predisposition to attacks of either trifacial neuralgia or sick headaches, and the symptoms of either one or the other accompany the attacks of ptosis, which comes on early in the attack of pain, but in only a very few cases is there accompanying anæsthesia. The attacks are usually ushered in suddenly, with neuralgic pains or headache, nausea, and vomiting, which may be so slight as to be thought absent; soon after, the paralysis of one or all branches

of the motor oculi appears, when all the symptoms except the pain may cease; after a shorter or longer interval (a few days to a few months) it disappears for a time, to be followed after a week's, month's, to a few years' interval by a recurrence. The attacks may be accompanied by photophobia, swelling of lids, catarrhal or purulent discharge, paralysis of the other eye muscles, and, rarest of all, anæsthesia of any or all of the branches of the fifth cranial nerve. This latter symptom, in the five cases (including my own) in which it has occurred, has appeared on the same side as the pain and oculo-motor paralysis; in two cases involving the supraorbital branch of the fifth nerve only; in two cases both that and the infraorbital branch, and in one case all the *sensory* branches of the fifth nerve on the affected side. One, of course, at first naturally suspects syphilis or tumor, but the previous history of attacks, or symptoms accompanying the attacks, with lack of history or other symptoms of either of these diseases and their subsequent non-appearance, especially in the optic nerve, will serve to help differentiate these cases.

The prognosis varies. In some cases the patient has recurring attacks of the same character at varying intervals; in others the severity and frequency increase till in some the trouble becomes permanent, and yet in others the reverse has occurred—namely, less frequency and less severity, or, again, less frequency and more severity. Of course, this will remain the condition while the ætiology remains so obscure as it is and its treatment empirical and unsatisfactory. This consists in the treatment of the attack of neuralgia or migraine with quinine, arsenic, phenacetine, or aconitine; then the paralysis soon after disappears unless, in a later attack, it may become

permanent, usually when the patient has come to the years of adult life. In cases which are not typical and obstinate it is well to try antisyphilitic treatment, as they may be due to that diathesis or to commencing tumor.

After discussing the different views Knapp sums up the pathology of this disease as follows: "The most tenable hypothesis is, that recurrent motor-oculi paralysis is due to some vascular change, inflammation, or œdema in a focal lesion, involving the root of the third nerve. As the œdema or exudation subsides, the conducting power of the nerve is wholly or partly restored and the paralysis disappears. In some cases the lesion may involve several nerves or the exudation may affect only a part of the lesion, involving different nerves at different times. As the lesion progresses, it may finally affect the nerve so far as wholly to destroy its conducting power, leading to permanent and total paralysis. The few (three) reported autopsies confirm this hypothesis."

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